STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 11/08/16 through 11/09/16. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 150 certified bed facility was 125 at the time of the survey. The survey sample consisted of 15 current Residents reviews (Resident #101 through #115).	F 000		
F 204 SS=D	PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG CFR(s): 483.12(a)(7) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide sufficient preparation to ensure safe and orderly	F 204		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 1	F 204		

discharge from the facility for 1 of 15 residents in the survey sample, Resident #101.

Specifically, the facility staff failed to ensure a safe and orderly discharge from the facility on 10/27/16 for Resident #101. As a result, Resident #101 was not permitted back into the building from 6:00 p.m. on 10/27/16 until after 8:30 a.m. on 10/28/16 when an APS (Adult Protective Services) worker arrived at the facility and found Resident #101 at the front entrance with all of his belongings. Resident #101 spent the night outside of the facility in 40 degree weather.

The findings included:

Resident #101 was admitted to the facility on 3/21/16 for skilled nursing. Diagnoses for Resident #101 included but are not limited to anemia in chronic kidney disease (reduced delivery of oxygen to the tissues, due to kidney damage), non-Alzheimer's dementia, enterocolitis due to clostridium difficile (inflammation of small intestine and colon, due to bacteria), human immunodeficiency virus (impacting the immune system), muscle weakness, and mild cognitive impairment. Resident #101's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/20/16 coded Resident #101 with moderate cognitive impairment with a Brief Interview Minimum Status (BIMS-assessment tool) coded score of 9 out of 15. In addition, the Minimum Data Set coded Resident #101 requiring no assistance or set up and supervision only for Activities of Daily Living care (dressing, eating, and hygiene). Resident #101 was his own responsible party. Resident #101 was observed on 11/8/16 at approximately 2:20 p.m. The resident was observed to be disheveled in a ball

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 2	F 204		

cap and belt not properly affixed. The room was piled with boxes, belongings, and clothing in disarray.

On 11/8/16, Resident #101's clinical record was reviewed. The review showed a physician's order dated 8/31/16 to discontinue LOA (Leave of Absence) for Resident #101. Another physician's order dated 10/27/16 read, Resident #101 was discharged against medical advise (AMA).

The Release of Responsibility for Leave of Absence Form for Resident #101 was submitted by the facility. The form documented Resident #101's continued use of LOA from 5/23/16 through 10/26/16. The majority of the destinations documented on the LOA forms were to (name of a convenience store) within walking distance from the facility with no major roads to cross.

Within Resident #101's clinical record there were 13 AMA forms signed by Resident #101 prior to and including the date of 10/27/16 mentioned in the complaint. To collaborate the ongoing discharge process clinical nursing notes were reviewed for each AMA date. The following results were reviewed by three surveyors along with the DON (Director of Nursing), Social Service Director, and Administrator. The results documented:

#1. On 8/31/16 at 3:30 p.m. Resident #101 was notified that LOA order had been discontinued. Resident #101 refused to sign an AMA form at 6:00 p.m. According to nursing notes Resident #101 left the facility 10:45 p.m. returned to the facility at 11:07 p.m. with behaviors noted in the corresponding clinical nursing note (smelled of alcohol prior to and after his return). Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 3	F 204		

#101 also signed the LOA form on 8/31/16 out at 10:45 p.m. to (name of convenience store) and returned on 8/31/16 at 11:07 p.m.

#2. On 9/1/16 Resident #101 signed an AMA form and left the facility at 10:45 a.m. and returned to the facility on 9/1/16 at 11:25 a.m. with no behaviors noted in the corresponding clinical nursing note.

#3. On 9/11/16 Resident #101 signed an AMA form and left the facility at 5:00 p.m. and at 9:00 p.m. smoking in the courtyard and returned to the facility on 9/11/16 with no behaviors noted in the corresponding clinical nursing note. Resident #101 also signed the LOA form on 9/11/16 out at 5:00 p.m. to (name of convenience store) and returned 5:30 p.m.

#4. On 9/13/16 Resident #101 signed an AMA form and left the facility at 11:30 p.m. According to the clinical nursing note resident went to (name of convenience store) at 11:30 p.m. and did not return until after 12:45 a.m. on 9/14/16. No behaviors, only odors of smoke when he returned.

#5. On 9/15/16 Resident #101 signed an AMA form and left the facility at 2:55 p.m. and returned to the facility on 9/15/16 at 3:10 p.m. with verbal abusive behaviors towards staff prior to going out noted in the corresponding clinical nursing note.

#6. On 9/16/16 Resident #101 signed an AMA form and left the facility at 1:35 p.m. and returned to the facility on 9/16/16 at 11:00 p.m. with no behaviors noted in the corresponding clinical nursing note but smelling of alcohol. A nursing note on 9/16/16 documented at 9:55 p.m. facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 4	F 204		

called his cell phone with no answer; MD, Administrator and Nursing Supervisor made aware.

#7. On 9/17/16 Resident #101 signed an AMA form and left the facility at 11:15 p.m. to go to (name of convenience store) and returned on 9/18/16 at 12:15 a.m. with no behaviors (odor of smoke) noted in the corresponding clinical nursing note.

#8. On 9/18/16 Resident #101 signed an AMA form and left the facility at 7:30 p.m. and returned to the facility on 9/18/16 at 10:00 p.m. with no behaviors noted in the corresponding clinical nursing note.

#9. On 9/25/16 Resident #101 signed an AMA form and left the facility at 5:20 p.m. and returned to the facility on 9/25/16 at 6:00 p.m. with no behaviors noted in the corresponding clinical nursing note.

#10. On 9/27/16 Resident #101 signed an AMA form and left the facility at 5:05 p.m. and returned to the facility on 9/27/16 at an unknown, undocumented time with rude behaviors and yelled at staff noted in the corresponding clinical nursing note.

#11. On 10/10/16 Resident #101 signed an AMA form and left the facility at 5:15 p.m. with unknown, undocumented time of return and undocumented behaviors in the corresponding clinical nursing note.

#12. On 10/26/16 Resident #101 had no behaviors documented prior to leaving the facility at 5:00 p.m. through the laundry exit. According

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 5	F 204		

to the nursing note Resident #101 stated, "I will be back in a few hours." The note also explained the grounds were searched and MD and DON notified. Resident #101 returned to the facility at 9:30 p.m. and the nursing note documented that he was advised to sign out AMA if he wanted to leave the building. Resident #101 had no behaviors according to the documentation. Resident #101 signed the AMA form and the LOA form after he returned to the facility.

#13. On 10/27/16 Resident #101 signed an AMA form and left the facility at 6:00 p.m. and was not permitted to enter back into the building until the following day 10/28/16 after 8:30 a.m. when an APS worker arrived. A nursing note dated 10/27/16 at 18:00 (6:00 p.m.) documented that Resident #101 was discharged as he signed an AMA he returned and was informed that he was discharged and his belongings were given to him. The note also documented that the Police were called as Resident #101 was deemed to be discharged and trespassing, banging on the door and ringing the door bell, and threatening staff. The police spoke with the resident and the note documented the police told the resident that he had been discharged, not to go back into the building that he would be trespassing. No other mention of behaviors were noted for the shifts (3:00 p.m. 11:00 p.m. or 11:00 p.m. though 7:00 a.m.). The nursing note at 20:30 (8:30 p.m.) documented, "Resident had been verbally abusive and refusing to follow any redirection while packing belongings." No other notes were documented 10/27/16 after 20:30 (8:30) p.m.

The documentation established an ongoing pattern of the discharge process between Resident #101 and the facility. Resident #101

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 6	F 204		

signed out AMA 13 times from 8/31/16 though 10/27/16. Each time Resident #101 returned and was allowed back into the facility except for the one night in question on 10/27/16. The AMA form and process was used by the facility staff as if it were an LOA. During each AMA Resident #101 was not treated as discharged, was not given clothing, medications, or went through an admission process upon re-entry. Resident #101 was signed back into the facility each time except on 10/27/16.

On 11/8/16 at approximately 2:20 p.m. Resident #101 was interviewed. Resident #101 stated, "I only wanted to take a walk that's why I signed the paper [AMA form on 10/27/16]." He added, "The doctor said, 'Go back inside' and I was agreeing so I stayed on the property and tried to get back in and the staff [Administration #3] would not let me."

On 11/8/16 at 4:15 p.m. Resident #101's doctor was interviewed. Resident #101's doctor confirmed that Resident #101 signed out AMA on 10/27/16 and that Resident #101 decided to stay and not go anyway. He added, "Not sure what happened after that [the doctor left the facility]."

On 11/8/16 at 4:50 p.m. Administration #3 was interviewed. Administration #3 stated, "He [Resident #101] could not leave LOA but had to sign out AMA according to the order." Administration #3 added, "He [Resident #101] signed the AMA form around 6:00 p.m. and left for 20 minutes and wanted to come back and I told him, 'Once you sign out AMA that's a discharge.'" Administration #3 was aware that Resident #101 had signed out AMA and came

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 7	F 204		

back hours later on multiple occasions. When asked why this night (10/27/16) was different, Administration #3 answered, "That was the first time management had been here and I called the Director of Nursing and the Administrator."

Administration #3 also stated, "Resident [#101] would just come in and lay down and go to sleep [the other times] but this time he [Resident #101] was cursing, became aggressive and would not settle down when his behavior elevated I called the police." She explained further, "After the police came he [Resident #101] was there on the bench...with his belongings..all night and didn't move off ." Finally, Administration #101 explained that Resident #101 was admitted the next day (10/28/16) as the Social Worker assisted and since this incident there were no problems as he [Resident #101] was following the safety plan.

On 11/9/16 at approximately 3:45 p.m. the Facility Social Worker was interviewed. She stated, "We were working on discharge planning but he [Resident #101] was non-compliant with doctors orders not to leave the facility unsupervised. He wants independence to come and go." Also, she confirmed that Resident #101 had signed out multiple times AMA just to take a walk. On 10/27/16 the social worker was not at the facility during the incident. She explained, "I had already left the facility on 10/27/16 but on 10/28/16 the APS [Adult Protective Services] worker, DON, ADON [Assistant Director of Nursing] and the APS Supervisor [via phone] made a safety plan and he [Resident #101] was readmitted if he would agree to follow it." She added, "He has followed it."

On 11/9/16 at approximately 11:30 a.m. the APS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 8	F 204		

worker was interviewed. She explained, "When the resident [#101] first came to facility he lacked capacity but regained health yet was non-complainant and could be disruptive." She confirmed that she had been working with Resident #101 and the facility. She also added, "The facility staff would not allow him [Resident #101] to sign out LOA to go to the store but would make him sign an AMA and always allow him to return." On 10/27/16 according to the APS worker, "He [Resident #101] did not want to leave permanently, he intended to come back as he only wanted to take a walk." She also confirmed that Resident #101 was outside the facility all night with his items in boxes. She stated, "When I arrived [to the facility] around 8:30 [a.m.] he was there sitting outside, calm with boxes." Finally she stated, "The facility staff had not issued him a 30 day discharge notice but made him sign AMA...this was his process in order to go for a walk."

On 11/9/16 at 11:45 a.m. the Ombudsman arrived and was interviewed. According to the Ombudsman the facility had issued a 30 day discharge notice and he presented a copy of this notice. The Ombudsman explained, "The 30 day discharge was dated 10/28/16 for violation of the smoking policy and the leave of absence policy." He also added, "This [incident on 10/27/16-where the resident was outside all night] was an involuntary and unsafe discharge...and he [Resident #101] was forced to sign an AMA for an LOA."

On 11/9/16 at 2:04 p.m. in a debriefing meeting with three surveyors, the DON, and the Social Worker, the Administrator was asked if he would do anything different in regards to the discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 9	F 204		

process for Resident #101, and he answered, "I would still discharge and now serve him with a 30 day [discharge notice] and I will find him a placement safe for him." After speaking with the Ombudsman, the Social Worker had determined to void the current 30 day discharge notice dated 10/28/16 and had not yet re-issued a 30 day discharge notice based on other requirements.

On 11/9/16 at 3:06 p.m. The DON stated, "I had made him [Resident #101] sign AMA form to protect the nursing staff [in case something happened to resident while out]. The DON also confirmed that this pattern of signing out AMA was discussed in Stand-up, daily morning meetings with staff including the Administrator.

On 11/9/16 at approximately 3:10 p.m. according to the Administrator, he was not aware of all 13 AMA discharges from 8/31/16 through 10/27/16. He did know of several times this occurred as he stated, "I knew about maybe 3 to 4 times". Finally the Administrator stated, "If I knew sooner [about all 13 times signing out AMA], then I would issue a 30-day [discharge notice] probably after the second, third, or fourth time."

The facility Transfer and Discharge Notice Policy with a revision date of September 2012 documented: "Our facility shall provide a resident and/or the resident's representative with a thirty day written notice of an impending transfer or discharge." The policy and implementation list 8 exceptions: necessary for resident's health, resident no longer needs services, safety and health of individuals in facility, failed to pay after reasonable and appropriate notice, urgent medical needs, resident has not resided in facility for 30 days or the facility ceases to operate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 10	F 204		

Resident #101 did not meet any of the exceptions listed on the night of 10/27/16 when he was forced to sign an AMA discharge form with every intent of returning to the facility.

The facility policy titled, "Against Medical Advice Discharge" was not dated. The policy documented: "The attending physician will write an order for all discharges from the facility. Any discharges against the advice of the attending physician will require facility administration to have a signed statement from the resident or responsible party to release the facility from all liability associated with the discharge." The Procedures for the policy included the following six steps:

1. The attending physician must be contacted prior to the release of a resident from the facility. If the physician cannot be reached or if permission for discharge is not granted, the discharge is considered to be "against medical advice."
2. The executive director is to be notified of the situation before further action is taken.
3. The resident and/or family must sign an Against Medical Advice Form designating that the discharge is against the advice of the physician, that the facility is released from all liability, and that the resident is responsible for all costs that the health insurance will not cover as a result of the AMA discharge.
4. This form includes the date and time, name of the facility, name and signature of the resident or legal representative, and signatures of two witnesses from the facility.
5. If resident or responsible party refuses to sign the form, two witnesses from the facility must sign the form and document accordingly.
6. A copy of this statement will be filed in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 11	F 204		

medical record behind the face sheet.

The Against Medical Advice Discharge Form (mentioned in the policy) had no revision date. This form included: date, time, and this statement: "This is to certify that I (name of resident) a resident in (name of the facility), am being discharged against the advice of the attending physician and the facility administration. I acknowledge that I have been informed of the risks involved and hereby release the attending physician and the facility from all responsibility for and from anything that may result from such discharge. I am aware that I will be responsible for any costs incurred that my insurance company refuses to cover.
Three signatures follow, the resident and two witnesses. At the bottom a final paragraph reads, "Authorization must be signed by the resident, by the nearest relative in the case of a minor, or by the Durable Power of Attorney when the resident is physically or mentally incompetent."

The facility staff was asked to provide a Resident's Rights Policy. The Policy presented did not have a revision date but the Administrator presented it as the policy followed. The Resident's Rights Policy documented under the title, "Rights During Transfers and Discharges" read, "Remain in the nursing facility unless a transfer or discharge: a. is necessary to meet resident's welfare; b. appropriate because health has improved and no longer requires nursing home care; c. is needed to protect the health and safety of residents and staff; d. is required because the resident has failed after reasonable notice, to pay the facility charge for an item or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. BUILDING _____ B. WING _____	C 11/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEACON SHORES NURSING & REHABILITATION	**340 LYNN SHORES DRIVE VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 12 service provided at the resident's request. Receive thirty-day notice of transfer or discharge which includes reason, effective date, location to which the resident is transferred or discharged, the right to appeal, and names, address, and telephone of the state long-term ombudsman. Safe transfer or discharge through sufficient preparation by the nursing home. The facility administration was informed of the findings during a briefing on 11/9/16 at approximately 2:05 p.m. The facility did not present any further information about the findings. Complaint deficiency	F 204		